



**Arizona Department of Health Services**  
**Invasive *Streptococcus pneumoniae* (ISP) Surveillance**  
**Supplemental Form (12/6/2004)**

Complete Communicable Disease Report form and this form if *Streptococcus pneumoniae* has been isolated from a normally sterile site.

**Case's Name (last name, first name):** \_\_\_\_\_ **2. Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Daycare:** Does patient attend daycare? ☐ Y ☐ N ☐ DK  
(Daycare is defined as a supervised group of 2 or more unrelated children for > 4 hours/week.)

**Residence/location at time of onset:**

- |                                  |  |   |                                     |                                  |
|----------------------------------|--|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Home    | <input type="checkbox"/> Long term care facility | <input type="checkbox"/> Acute Care Hospital  | <input type="checkbox"/> Retirement | <input type="checkbox"/> Home    |
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Homeless                | <input type="checkbox"/> Other, specify _____ |                                     | <input type="checkbox"/> Unknown |

**Date of admission:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Outcome:** \_\_\_\_ (1=Lived, 2= Died, 3=Transferred)

**Disease(s) caused by *Streptococcus pneumoniae*:** CHECK ALL THAT APPLY

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Primary Sepsis (without focus) | <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Endocarditis     | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Secondary Bacteremia           | <input type="checkbox"/> Meningitis                   | <input type="checkbox"/> Septic Arthritis | <input type="checkbox"/> Sinusitis   |
| <input type="checkbox"/> Otitis Media                   | <input type="checkbox"/> Other, please specify: _____ |   |                                      |

**Date of symptom onset:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (mo/day/yr) **DNR?** ☐ Y ☐ N ☐ DK

**Positive *Streptococcus pneumoniae* cultures:**

Source \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Source \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Serotype**

What was the serotype? \_\_\_\_\_ ☐ Not tested or unknown ☐ Not typable

**Underlying illness or Prodrome:** CHECK HERE IF NONE ☐

CHECK ALL THAT APPLY

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Chronic lung disease                  | <input type="checkbox"/> Splenectomy/asplenia | <input type="checkbox"/> Malnourished        | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Chronic heart disease                 | <input type="checkbox"/> Alcohol abuse        | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Renal failure |
| <input type="checkbox"/> Diabetes mellitus                     | <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Drug abuse    |
| <input type="checkbox"/> Past Smoker                           | <input type="checkbox"/> Current Smoker       | <input type="checkbox"/> Smokeless Tobacco   |  |
| <input type="checkbox"/> Other immunosuppressive disease _____ |   |  |  |
| <input type="checkbox"/> Organ transplant                      | type _____                                    |  |  |
| <input type="checkbox"/> Malignancy (non-skin)                 | type _____                                    |  |  |

**Form completed by:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Facility:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Mail completed form to: Infectious Disease Epidemiology Section  
150 N. 18<sup>th</sup> Avenue, Suite 140  
Phoenix, AZ 85007  
FAX: (602) 364-3199  
Phone: (602) 364-3676

**VACCINE**

DID PATIENT RECEIVE THE PNEUMOCOCCAL VACCINE? ☐ Y ☐ N ☐ DK      IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION:

DATE GIVEN: \_\_\_/\_\_\_/\_\_\_ VACCINE NAME / MANUFACTURER \_\_\_\_\_ LOT NUMBER

DATE GIVEN: \_\_\_/\_\_\_/\_\_\_ VACCINE NAME / MANUFACTURER \_\_\_\_\_ LOT NUMBER

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**SUSCEPTIBILITY METHOD: 1 = Agar:** Agar Dilution Method; **2 = Broth:** Bacterial Broth Dilution; **3 = Disk:** Bacterial Disk Diffusion (Kirby Bauer); **4 = Strip:** Antimicrobial Gradient Strip (E-Test®) **8 = MIC** Result of unknown method **9 = Unknown**

**MIC RESULT:** Enter the numeric MIC result (i.e., >=2)

**S, I, R RESULT:** **S** = Susceptible; **I** = Intermediate; **R** = Resistant

Antimicrobial Agent	Susceptibility Method	MIC Result	S, I, R Result
<b>Ampicillin</b>			
<b>Amox/Clav (Augmentin)</b>			
<b>Azithromycin</b>			
<b>Cefotaxime</b>			
<b>Ceftriaxone</b>			
<b>Cefuroxime</b>			
<b>Chloramphenicol</b>			
<b>Ciprofloxacin</b>			
<b>Clindamycin</b>			
<b>Erythromycin</b>			
<b>Gatifloxacin</b>			
<b>Levofloxacin</b>			
<b>Penicillin</b>			
<b>Rifampin</b>			
<b>Tetracycline</b>			
<b>TMS</b>			
<b>Vancomycin</b>			